



# WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

## PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

\_\_\_\_\_ and assign directly to

Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date

Relationship to Patient

## PHONE NUMBERS

Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Spouse's Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

## EYE HEALTH HISTORY

Physician's Name \_\_\_\_\_

Date of last visit \_\_\_\_\_

Date of last eye exam \_\_\_\_\_

Name of doctor \_\_\_\_\_

Do you wear glasses?  Yes  No

All the time  Occasionally  
 Reading  Driving  TV

Do you wear contacts?  Yes  No

Type \_\_\_\_\_ Hours/Day \_\_\_\_\_

Describe any problems you have with your contacts \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bloodshot Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision - Distance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision - Near	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discharge from Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells, Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No

# HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Type _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? _____	Number of children _____	
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco use _____	Alcohol use _____	

## MEDICATIONS

List any medications you are currently taking, including eye drops:

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

## ALLERGIES

List your allergies to medications or other substances:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

\_\_\_\_\_ for any services furnished to me by that provider.  
Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

\_\_\_\_\_  
Signature of Beneficiary, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Beneficiary, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Beneficiary



# Receipt of Notice of Privacy Policies & Consent Form

Advantage Eye Care/Joseph W. Laya, O.D.  
1751 Hartnell Ave., Ste. 1  
Redding, CA 96002  
530-223-2325  
Fax: 530-223-2252

Patient Name: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Patient Phone Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The Notice of Privacy Practices you have been given describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform healthcare operations. You also signify that you have received a copy of our Notice of Privacy Practices.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

**I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Advantage Eye Care.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Name

Source of Authority: \_\_\_\_\_

## **ADVANTAGE EYE CARE INSURANCE PARTICIPATION:**

**Vision Insurance:** Our office accepts most vision insurance plans. You may have vision insurance separate from your major medical plan. Vision insurance is utilized for a comprehensive eye examination for ocular wellness. Some vision plans also allow for optical benefits, which can be used to supplement the cost of vision correction via glasses and/or contact lenses.

**Major Medical Insurance:** Our office accepts most major medical insurance plans. We will bill all pertinent medical charges through your major medical insurance.

**Comprehensive Eye Examinations:** Routine annual eye examinations are billable to your vision insurance. You will be responsible for any co-pay at the time of examination. In the event that pathology is detected during a routine eye exam, additional testing or procedures may be indicated.

**Additional Testing and Procedures are at an additional cost and will be billed to your major medical insurance.**

**Pathology Focused Eye Examination:** Examinations for a medical complaint will be billed through your major medical insurance.

**Medical Diagnosis:** Diagnosis by your doctor of a medical condition during a Comprehensive Eye Examination or Pathology Focused Eye Examination.

**Additional Testing and Procedures:** Testing to evaluate, diagnose, or manage a diagnosed pathology. Additional testing and procedures may be independent from or in addition to a comprehensive eye exam. These tests may include Fundus Photography, Extended Ophthalmoscopy, Gonioscopy, Visual Fields, Pachymetry, Eye Lash Epilation, Removal of Foreign Bodies, Serial Tonometry, Punctal Occlusion and Pupilometry. These will be billed to your major medical insurance.

**I have read and understand how Advantage Eye Care will bill my insurance, if covered:**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_